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## **Changing the way “we” view and talk about Frailty...**

### **Key words**

Frailty, Older People, Asset-based Comprehensive Geriatric Assessment

### **Introduction**

This commentary discusses the perception of frailty by different key stakeholders - most notably older people. It considers the need to integrate predominantly medically-driven understandings of frailty within a wider conceptual framework. This is imperative if the potential of frailty as a construct, around which the optimisation of health and well-being of older people can take place, is to be realised.

### **The Medical View of Frailty**

The underpinning of Geriatric Medicine is the understanding that specific therapeutic approaches work better for older people with multiple conditions and physical dependency, with or without cognitive impairment. The growing evidence-base around Comprehensive Geriatric Assessment [1] provides an increasingly robust basis for the specialty to establish itself as part of the medical mainstream. CGA, at its most inclusive, incorporates models of integrated care, case management and person- and relationship-centred care. It provides a language to describe both the form and function of geriatric medicine. However, there remains a lack of clarity about which older people are most likely to benefit from CGA [2]. Chronological and/or biological age, comorbidity and dependency are at best correlates to describe what geriatric clinicians consider when determining which people are most likely to benefit from CGA.

Alongside CGA, the concept of ‘frailty’ has evolved [3]. In the hands of the research commentariat, it has developed from something which “we know when we see it” into an ordinal variable that can be defined, measured and evaluated. This development has been enthusiastically welcomed both by geriatricians and the broader healthcare community. Frailty policies, frailty units and frailty checklists are epiphenomena associated with this dialogue. However we suggest that other stakeholders are less clear about the benefits of the concept of frailty and that a more nuanced dialogue about what frailty means is probably required.

### **The Patient and Public View of Frailty**

In particular, patients and the public at large, challenge our assumptions about the value of frailty. There is growing evidence of antipathy to the term from older people, from non-specialist clinicians and from policy makers. Recent stakeholder research published by Age UK in conjunction with the British Geriatrics Society (BGS)[4] noted that older people and their carers associated the term with end-of-life, cancer syndromes and high degrees of functional dependency. Respondents universally regarded “frail” as a negative label. Older

people described frailty as something they could recognise in others but which they would never use to describe themselves. This supports findings in Nicholson's [5] doctoral thesis on the experience of older people living with frailty. Participants used frailty as a term of separation – given to others who were seen to be more unwell and needing more care than themselves. Importantly, in both pieces of work, participants recognised their bio/psycho/social vulnerabilities. However, frailty was associated with giving up and was not to be identified with, even by those people who had high support needs. This is perhaps not surprising given the etymology of frailty. The Oxford English Dictionary defines frailty as, “a fault and infirmity with both physical and moral dimensions”. A qualitative study of 29 older people aged 66 – 98 found that ‘most participants actively resented the identity, even those who could be classified as frail using objective criteria [6]. This conceptual mismatch is not a linguistic tic exclusive to the English language – a Dutch study considering 641 older patients found that 47% of those with frailty did not recognise either frailty, or an increased care need associated with frailty, in themselves [7]. Grenier[8] argues that older people with frailty themselves differentiate between being and feeling frail. The label of frailty is actively resisted as older people distinguish between the body one is (self-identity) and the body one has - a physical, vulnerable, and objectified social identity. For some social scientists [9] the conceptualisation of frailty is itself a separating practice, with frailty being shaped by societal fears of an adverse, undesirable yet undefined future.

Current conceptualisations of frailty can lead us to view an entire person through a particular lens. The WHO report on Ageing and Health [10] defines frailty (or the frail older person) as ‘Extreme vulnerability to endogenous and exogenous stressors that expose an individual to a higher risk of negative health related outcomes’. Richardson et al [11] argue that health-care professionals and researchers need to be aware of the unintended negative consequences of the constructs of frailty. They suggest labelling someone as frail can lead to the stereotyping of an older person as failing to age well, which can be internalised by older people and cause unnecessary suffering. Thus paradoxically, the very term used clinically to identify people for whom health can be optimised, is experienced by many as a term that labels people as failing.

### **A More Comprehensive View of Frailty**

Thus we are challenged, within conceptualisations of frailty, to move beyond our current emphasis on problem-based deficit models of a failing body system to a salutogenic approach[12], which is to say one which focusses on adaptation to life and the resilience of older people. Nicholson [134] suggests that barriers to maximising physical capabilities and the benefits of a hospital stay are the attitudes, behaviours and preoccupations of care staff towards the older people for whom they care. Whilst acute care settings often see older people at their most frail, this can become the only context within which they are visible. The study noted that rarely were pre-admission levels of a person's capability sought during an acute admission and the clinical management of frailty, including Comprehensive Geriatric Assessment, did not always take account of the strategies that older people themselves employed to deal with both their vulnerabilities and self-perceived strengths. Rather, care interventions often focused on problems and incapacity, which perversely may make older

people become or feel frail. Therein lies the paradox – older people with frailty are the survivors, outliving the majority of their birth cohort, and yet often that very resilience is undermined unless we intentionally and actively hold the capacity and strategies of continuity that older people employ, alongside their potential and actual vulnerability. One way forward may be to ensure that every Comprehensive Geriatric Assessment contains an explicit question around the current strengths of older people in managing their everyday life.

### **Changing the Conversation**

Perhaps what our patients, their carers and policy makers are trying to tell us is that frailty and CGA are only part of a holistic approach to health and well-being. Although geriatricians have cast off some of the shackles of the traditional medical diagnostic paradigm, they have made incomplete progress. The World Health Organisation definition of health as a state of complete physical, mental and social well-being will not be fully encapsulated by CGA, or any other model of assessment, so long as the assessment continues to focus on describing impairment, limitation, restriction and deficit. Frailty – whether adopting phenotypic, accumulation of deficit or lay definitions – is similarly restrictive. It can describe the “glass half empty”, but not the ways in which the glass is half full. Accumulation of deficit is, of course, part of the ageing process. What patients seem to be telling us is not that they deny this but that their health and wellbeing is defined by what they can, as much as by what they cannot, do. Having established the notion that frailty is an insufficient concept around which to base all discussions about ageing and functional decline, the question then becomes how best to position frailty?

Of note is the AgeUK/BGS report that identified that many non-geriatrician healthcare practitioners still see frailty as something which they “know when they see”. Strikingly, their constructs aligned more closely to the lay narrative. It is possible that, in conversations around frailty, these professionals come closer to a common understanding with patients about the term than geriatricians do – and such shared understanding is a good basis for shared decision making. This is in line with the assertion of Whitson and colleagues [14], who have suggested that attaching a frailty label by “gestalt” – frailty known when seen – might still have clinical utility, even if to do so places the user of the terminology at odds with emerging consensus definitions.

We would argue that, whilst frailty terminology has its uses, a more nuanced understanding is required that recognises, alongside its limitations, the different ways in which the terminology is used. These discussions need to be placed within a bigger picture, starting with what older people can do, and what are their desires for services and care. In England, this fits well with policies which increasingly seek to build service models around individual voice and choice- summed up in the ‘‘No decisions about me without me’’[15] mantra.

### **Conclusion**

Whilst expert gerontologists continue to debate whether frailty is better characterised by phenotypic or accumulation of deficit models there is, we suggest, an important wider

discussion to be had. This is to engage with the population of older people, generalist health/social care workers and policy makers whose understandings of frailty crucially shape behaviour and clinical care. Failure to engage in this wider dialogue risks confusion, alienation and a failure to connect with the very people who most stand to benefit from targeted services. In conclusion, frailty is a concept with utility for geriatricians, health care services and broader society but it comes with significant limitations. We can use it but we should not be limited by it. We should be seeking to find ever more inclusive ways to define the population most likely to benefit from the inclusive, broad, detailed, iterative approach to healthcare for which geriatricians advocate. CGA is less limited as a concept than is frailty and is capable of assimilating asset-based models of health and wellbeing as it evolves. Let us not limit our potential to achieve impact for older people by constantly dwelling upon their deficits.

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